



**Florida Network for Youth and Family Services
Compliance Monitoring Report for FY 2025-2026**

Nehemiah Educational and Economic Development (N.E.E.D)

611 N. Wymore Rd. Ste.# 203
Winter Park, FL 32789

December 17, 2025

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Nehemiah Educational and Economic Development (NEED), Inc for the FY 2025-2026 at its program office located at 611 N. Wymore Rd. Suite 203, Winter Park, FL 32789. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Nehemiah Educational and Economic Development, Inc. is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2025 through June 30, 2026.

The compliance monitoring review was conducted by Marcia Tavares, Consultant for Forefront LLC. Agency representatives from NEED present for the entrance interview were Venus Highsmith, Program Director; Minne Jackson, Data Administrator; Estoria Patterson, Program Manager; counselors Jarvis Mays, Anthony Johnson; and Edward Ricks, Case Manager. The last onsite QI visit was conducted on November 20, 2024.

In general, the Reviewer found Nehemiah Educational and Economic Development, Inc. is in compliance with specific contract requirements. **Nehemiah Educational and Economic Development, Inc. received an overall compliance rating of 90% for achieving full compliance with nine indicators** of the CINS/FINS Monitoring Tool. There were no recommendations as a result of the monitoring visit; however, one corrective action was identified for a review item rated as unacceptable.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 12-17-2025-2026

Agency Name: Nehemiah Educational and Economic Development Inc.					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 611 N. Wymore Rd., Ste. 203 Winter Park, FL 32789		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): December 17, 2025		
Explain Rating							
Major Programmatic Requirements	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I - The program currently has two peer reviewers who were re-certified: Minnie Jackson/ Data Administrator and Venus Highsmith/ Area Director. Two additional staff, Anthony Johnson and Jarvis Mays, need to successfully complete the Peer Refresher training to be recertified. Provider staff participated in a QI review during the 12-month period of the contract.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I - The Florida Network is the sole funding source for N.E.E.D.	

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D - The program has a certificate of liability showing coverage produced by All Assurance, LLC DBA Malcolm Insurance Agency with coverage afforded by underwriters at Lloyd's London with the following coverages and limits effective 10/30/2025 - 10/30/2026: General Liability, \$1,000,000 each occurrence, \$50,000 damage to rented premises, \$5,000 med exp (any one person), \$1,000,000 personal and adv injury, \$3,000,000 general aggregate, \$1,000,000 products, Professional liability \$1,000,000 each occurrence and \$3,000,000 aggregate. Automobile Liability- N/A as NEED does not have a vehicle to transport youth. The certificate lists the Florida Network of Youth and Family Services as an additional certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I - The Executive Director reports no corrective action items from any external funding sources.	

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Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D – The agency maintains minimal fiscal policies and procedures regarding internal controls for billing and accounts receivable, bank reconciliations, in-kind contributions, and revenue. The policies and procedures appear to be consistent with GAAP and provide limited controls.
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D - The agency maintains a general ledger and corresponding source documents. The general ledger reviewed dated as of November 30, 2025, is set up to track the activity of the grant separately. The agency uses Quick Books accounting system to manage day-to-day bookkeeping. Funds are separated by class codes and allocated accordingly.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I – Per the Executive Director, the program does not use petty cash.
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D – Wells Fargo Bank Statements and reconciliation reports for July – Corrective Action 1)

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invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). ON SITE						November 2025 were reviewed. Evidence of bank reconciliations was observed to be completed and signed by both the President/CEO and bookkeeper; however, they were all dated December 15, 2025, suggesting monthly reconciliations are not conducted in a timely manner, within 6 weeks of receipt of the bank statements.	Provider must ensure bank reconciliations are conducted on a timely basis, within 6 weeks of receipt of the bank statement.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I – Per the Executive Director, there were no purchases made with Florida Network Funds for the review period.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D – NEED Transaction Detail for the CINS/FINS account for the period July-November 2025 was reviewed. The report shows bi-weekly federal unemployment, social security, and payroll taxes deducted and paid through Wells Fargo bank for each employee.	

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D - Budget to actual reports for July-November 2025 were reviewed. The reports are prepared on a monthly basis by the bookkeeper and reviewed by the President/ CEO. Variances are discussed and reported to the board. Board meeting minutes for March, July and October 2025 show finance reported to the Board at each meeting.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I - The agency does not meet the income threshold requirements for a single audit.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D - The agency maintains confidentiality policies and additional policies and procedures to ensure the security and privacy of all employees and client data. Personal information is not easily	

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o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. ON SITE						complete the Universal Agreement/Emergency Disaster Shelter document.	

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CONCLUSION

Nehemiah Educational and Economic Development Inc. has met the requirements for the CINS/FINS contract as a result of full compliance with nine applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Five of the fifteen indicators were not applicable and included 1) Additional Contracts; 2) External/Outside Contract Compliance; 3) Florida Network Inventory; 4) Petty Cash System; and 5) Annual Financial Audit. There are no recommendations cited but one corrective action is required as a result of the contract monitoring visit. Consequently, **the overall compliance rate for this contract monitoring visit is 90%**. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTION

Corrective Action (1)

Provider must ensure bank reconciliations are conducted on a timely basis, within 6 weeks of receipt of the bank statement.

The provider must submit a corrective action plan to address corrective action (1) cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Nehemiah Educational and Economic Development, Inc.
CINS/FINS Program

Date: December 17, 2025

Compliance Monitoring Services Provided by



December 17, 2025

CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

1.0 Background Screening of Employees/Volunteers	Satisfactory
1.1 Annual Affidavit of Compliance with Good Moral Character Standards	Satisfactory with Exception(s)
1.2 Provision of an Abuse Free Environment	Satisfactory with Exception(s)
1.3 Incident Reporting	Satisfactory
1.4 Training Requirements	Satisfactory
1.5 Data Entry & Collection	Satisfactory
1.6 Analyzing and Reporting	Satisfactory with Exception(s)
1.7 Client Transportation	Not Applicable
1.8 Client Contact	Satisfactory
1.9 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Domain 3: Screening, Assessment & Case Management

3.2 Admission Process	Satisfactory with Exception(s)
3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)	Limited
3.4 Case Management, Counseling & Non-Residential Services Policy	Satisfactory with Exception(s)
3.5 Adjudication Services: Case Staffing	Satisfactory
3.6 Adjudication Services: CINS Petition Process	Satisfactory
3.7 Service Plan	Limited
3.8 Youth Records	Satisfactory
3.10 Discharge and Follow Up	Satisfactory with Exception(s)

Percent of indicators rated Satisfactory: 75 %
Percent of indicators rated Limited: 25 %
Percent of indicators rated Failed: 0 %

Domain 6: Medication Management

6.2 Suicide Prevention	Satisfactory
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Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 88.89 %
Percent of indicators rated Limited: 11.11 %
Percent of indicators rated Failed: 0 %

December 17, 2025

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
 Guz Mazorra – Regional Monitor, Department of Juvenile Justice
 Cinthya Muniz - Children's Home Society Osceola

December 17, 2025

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of Domain (1) - Domain (6), which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2025).

Persons Interviewed

- | | | |
|--|---|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse – Full time |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Counselor Non-Licensed | <input type="checkbox"/> Nurse – Part time |
| <input type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Advocate | <input type="checkbox"/> # Case Managers |
| <input checked="" type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Direct – Care Full time | <input type="checkbox"/> # Program Supervisors |
| <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Direct – Part time | <input type="checkbox"/> # Food Service Personnel |
| <input type="checkbox"/> Program Manager | <input type="checkbox"/> Direct – Care On-Call | <input type="checkbox"/> # Healthcare Staff |
| <input type="checkbox"/> Program Coordinator | <input type="checkbox"/> Intern | <input type="checkbox"/> # Maintenance Personnel |
| <input type="checkbox"/> Clinical Director | <input type="checkbox"/> Volunteer | <input checked="" type="checkbox"/> <u>Data Administrator</u> |
| <input type="checkbox"/> Counselor Licensed | <input type="checkbox"/> Human Resources | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Table of Organization | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> # Health Records |
| <input type="checkbox"/> Logbooks | <input type="checkbox"/> Key Control Log | <input type="checkbox"/> # MH/SA Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input type="checkbox"/> Fire Drill Log | <input type="checkbox"/> 1 # Personnel /Volunteer Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> Medical and Mental Health Alerts | <input type="checkbox"/> 5 # Training Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | <input type="checkbox"/> 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | <input type="checkbox"/> 4 # Youth Records (Open) |
| <input type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> List of Supplemental Contracts | <input type="checkbox"/> # Other: ___ |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Vehicle Inspection Reports | ___ |

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory & Storage | <input type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts | <input checked="" type="checkbox"/> Signage that all youth welcome |
| <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Staff Interactions with Youth | <input type="checkbox"/> Census Board |

Surveys

- | | | | |
|---------------------------------------|--|-------------------------------------|--------------------------|
| <input type="checkbox"/> 0 # of Youth | <input type="checkbox"/> 5 # of Direct Staff | <input type="checkbox"/> # of Other | <input type="checkbox"/> |
|---------------------------------------|--|-------------------------------------|--------------------------|

Comments

A Quality Improvement Program Review was conducted for FY 2025-2026

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Narrative Summary

Nehemiah Educational and Economic Development, Inc. is a 501(C)3 organization located at 611 N. Wymore Rd., Suite 203, Winter Park, FL 32789. Nehemiah Educational and Economic Development, Inc. (N.E.E.D) serves Orange County and all of Judicial Circuit 9, in various school campuses and in-homes.

The overall findings for the program QI Review are summarized as follows:

Domain 1: There are nine indicators for Domain 1.

Indicator 1.0 Background Screening of Employees/Volunteers was rated Satisfactory

Indicator 1.1 Annual Affidavit of Compliance with Good Moral Character Standards was Satisfactory with Exception(s)

Indicator 1.2 Provision of an Abuse Free Environment was rated Satisfactory

Indicator 1.3 Incident Reporting was rated Satisfactory

Indicator 1.4 Training Requirements was rated Satisfactory

Indicator 1.5 Data Entry & Collection was rated Satisfactory

Indicator 1.6 Risk Management/ Analyzing and Reporting Information was rated Satisfactory with Exception(s)

Indicator 1.7 Client Transportation was rated Not Applicable

Indicator 1.8 Client Contact was rated Satisfactory

Indicator 1.9 Outreach Services was rated Satisfactory

Domain 3: There are eight indicators for Domain 3.

Indicator 3.2 Admission Process was rated Satisfactory with Exception(s)

Indicator 3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment) was rated Limited

Indicator 3.4 Case Management, Counseling & Non-Residential Services Policy was rated Satisfactory with Exception(s)

Indicator 3.5 Adjudication Services: Case Staffing was rated Satisfactory

Indicator 3.6 Staffing and Youth Supervision was rated Satisfactory

Indicator 3.7 Service Plan was rated Limited

Indicator 3.8 Youth Records was rated Satisfactory

Indicator 3.10 Discharge and Follow Up was rated Satisfactory with Exception(s)

Domain 6: There are five indicators for Domain 6.
Indicator 6.2 Suicide Prevention was rated Satisfactory

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Domain 3:

- 3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment): Out of the eight files reviewed, five of them showed that the NIRVANA was entered in NetMIS after the three days of completion. The remaining three showed they were entered on time. Two of the files reviewed contained the supervisor's signature after the seven days window. Only two out of the eight files reviewed needed a re-assessment. One was completed on time; however, one was due by 11/26/25 and was not completed until 11/30/25.
- 3.7 - Service Plan: One of the records did not include any documentation of services to be provided and/or location. Actual completion date is not documented on one of four applicable service plans. None of the eight cases reviewed showed where the licensed professional reviewed the service plan within seven days of plan completion. The clinical summary completed documenta the service plan reviews around a 30 day timeframe. Thirty-day service plan reviews were not completed timely in three of the eight records reviewed. Sixty-day service plan reviews were not completed timely in five of the eight records reviewed. Ninety-day service plan reviews were not completed timely in three applicable records reviewed.

December 17, 2025

CINS/FINS QUALITY IMPROVEMENT TOOL		
Quality Improvement Indicators and Results: Compliance: The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. Exception: The findings observed or reviewed indicate the practice is not aligned with the requirement(s) for the review item at the time of the review. Not Applicable: The item reviewed is not applicable for this review item(s) or the agency is not contracted to provide services related to the review item. E.g. If the agency has a policy that states they will not transport under any circumstance, Indicator 1.06 would be not applicable.	Summary/Narrative Findings: This column provides a comprehensive narrative summary of each assigned QI indicator. It highlights areas where the program demonstrated compliance, outlines the evidence supporting those determinations, and provides detailed explanations for any deficiencies or exceptions. Together, these findings offer clear justification for the specific domain ratings and present a balanced view of program performance.	
Domain One – Background Screening and Compliance		
1.0 - Background Screening		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.0		Yes
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0		Yes
		Policy #1.0 Background Screening and Annual Affidavit of Good Moral Character was approved by the Executive Director on 10/31/2025. The program utilizes the Avatar suitability assessment tool and has established a passing score of 55.
A total of one file(s) were reviewed during this evaluation period. Of these, zero new hire file(s) and one 5-year rescreen file(s) were reviewed. The sample included one employee(s) and zero volunteer(s).		
Suitability Assessment		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Not Applicable	The provider did not hire any new program staff during the annual review.
For any applicant that did NOT pass the initial suitability assessment: Applicant retook the assessment and passed within five (5) business days of the initial attempt, not to exceed three (3) attempt within thirty (30) days.	Not Applicable	The provider did not hire any new program staff during the annual review.

December 17, 2025

<p>Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.</p>	<p>Not Applicable</p>	<p>The provider did not hire any new program staff during the annual review.</p>
<p>New Hire</p>		
<p>For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.</p>	<p>Not Applicable</p>	<p>The provider did not hire any new program staff during the annual review.</p>
<p>For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.</p>	<p>Not Applicable</p>	<p>The provider did not utilize any contractors, volunteers or interns during the annual review who met the criteria for background screening.</p>
<p>For those with ineligible background screenings, the exemption was obtained prior to working with youth.</p>	<p>Not Applicable</p>	<p>The provider did not hire any new program staff during the annual review.</p>
<p>E-Verify</p>		
<p>The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.</p>	<p>Not Applicable</p>	<p>The provider did not hire any new program staff during the annual review.</p>
<p>5 Year Rescreening</p>		
<p>Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.</p>	<p>Compliance</p>	<p>All five-year re-screenings were completed on or before the employee’s five-year anniversary or fingerprint expiration date, whichever came first.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

December 17, 2025

1.1 - Annual Affidavit of Compliance with Good Moral Character Standards		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.1		Yes
		Policy #1.01 - Background Screening and Annual Affidavit of Good Moral Character was approved by the Executive Director on 10/31/2025.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	Exception	Documentation supported the agency submitted an Affidavit of Compliance with Level 2 Screening Standard (AACLSS) on 1/30/2024 (for 2023) and 12/8/2025 (for 2025); however, there is no evidence one was submitted for 2024.
Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	Exception	No email or fax documentation was provided to support submission of the AACLSS for 2024.
Additional Comments: There are no additional comments for this indicator.		
1.2 - Provision of an Abuse Free Environment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.2		Yes
		Policy 1.2, Abuse Reporting/Abuse Free Environment & Grievances was approved by the Executive Director on October 31, 2025.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation.	Compliance	The program maintains and enforces a written Code of Conduct that strictly prohibits physical abuse, profanity, threats, or intimidation. All staff demonstrate adherence to these standards.
The program has a process in place for reporting and documenting any child abuse hotline calls.	Compliance	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.
The agency is an abuse free environment.	Compliance	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from staff.
Additional Comments: There are no additional comments for this indicator.		

December 17, 2025

1.3 - Incident Reporting		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.3		Yes
		Policy 1.3, Incident Reporting was approved by the Executive Director on October 31, 2025.
Data sources Reviewed	Dates Reviewed	Logbook Dates for Sample Size:
CCC reports Incident reports Logbooks Interview with Program Staff	A review of the Department’s Central Communications Center (CCC) call log for the past 6 months revealed there were no incidents requiring a CCC report. The program's Incident Report Log was also reviewed from January 2025 – December 2025 which confirmed there were no reportable incidents during the review period. The program’s policy on incident reporting was also reviewed and revealed the policy includes reporting timeframes, follow-up, documentation, and supervisory review.	This program type is not required to maintain a logbook.
The program notified the Department’s CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	Not Applicable	A review of the Department’s Central Communications Center (CCC) call log for the past 6 months revealed there were no incidents requiring a CCC report.
The program completes follow-up communication tasks/special instructions as required by the CCC.	Not Applicable	There were no reportable incidents documented by the program.
Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	Not Applicable	NEED is not a shelter program.
Incidents are documented in the program logs, and CCC call is documented in the logbooks for Shelter programs.	Not Applicable	There were no reportable incidents documented by the program.

December 17, 2025

All incident reports are reviewed and signed by program supervisors/directors.	Not Applicable	There were no reportable incidents documented by the program.
Additional Comments: There are no additional comments for this indicator.		
1.4 - Training Requirements	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 1.4	Yes	
	Policy 1.4, Training was approved by the Executive Director on October 31, 2025.	
A total of 0 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 1 new hire staff and 5 annual staff files were reviewed for compliance with training completed within the required timeframe(s).		
Policy & New Hire Training		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	Not Applicable	During the annual compliance review period, there were no new hires. Consequently, there are no applicable new hire training records to review.
Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	Not Applicable	The program has no eligible new hires.
Pre-Service Training		
Agency policies and procedures	Not Applicable	The program has no eligible new hires.
Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	Not Applicable	The program has no eligible new hires.
File Documentation/Paperwork Requirements	Not Applicable	The program has no eligible new hires.
Confidentiality (FYSB / DCF / Skill Pro)	Not Applicable	The program has no eligible new hires.
CCC & Incident Reporting	Not Applicable	The program has no eligible new hires.
Child Abuse Reporting	Not Applicable	The program has no eligible new hires.
Client Intake & Screening	Not Applicable	The program has no eligible new hires.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	Not Applicable	The program has no eligible new hires.

December 17, 2025

Fire Safety Equipment (Skill Pro #215 or DCF)	Not Applicable	The program has no eligible new hires.
Medical and Mental Health Alert System	Not Applicable	The program has no eligible new hires.
Disaster Preparedness	Not Applicable	The program has no eligible new hires.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Not Applicable	The program has no eligible new hires.
CPR/First Aid (By CPR Certified Instructor)	Not Applicable	The program has no eligible new hires.
CINS/FINS Core	Not Applicable	The program has no eligible new hires.
Florida Network Youth Suicide Prevention	Not Applicable	The program has no eligible new hires.
Adolescent Development / Positive Youth Development	Not Applicable	The program has no eligible new hires.
Cultural Humility/Diversity	Not Applicable	The program has no eligible new hires.
Mental Health and Substance Abuse	Not Applicable	The program has no eligible new hires.
Skill Pro Required Trainings:		
Child Abuse: Recognition, Reporting and Prevention	Not Applicable	The program has no eligible new hires.
Equal Employment Opportunity	Not Applicable	The program has no eligible new hires.
Human Trafficking Intervention for Direct Care Staff	Not Applicable	The program has no eligible new hires.
Information Security Awareness	Not Applicable	The program has no eligible new hires.
Prison Rape Elimination Act (PREA) - Part 1	Not Applicable	The program has no eligible new hires.
Prison Rape Elimination Act (PREA) - Part 2	Not Applicable	The program has no eligible new hires.
Sexual Harassment	Not Applicable	The program has no eligible new hires.
Trauma Responsive Practices	Not Applicable	The program has no eligible new hires.
Additional FL Network Required Trainings:		
Naloxone Training	Not Applicable	The program has no eligible new hires.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Not Applicable	The program has no eligible new hires.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	Not Applicable	The program has no eligible new hires.
STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	Not Applicable	The program has no eligible new hires.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	The program has no eligible new hires.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	The program has no eligible new hires.

December 17, 2025

<p>Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>SNAP Support Overview *This training does not certify staff to facilitate SNAP (Not Required for SNAP Staff but offered for staff in between hire date and completing full SNAP Facilitator training) After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator</p>	<p>Not Applicable</p>	<p>The Program does not provide SNAP Services.</p>
<p>SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups) *If the trained staff has not facilitated groups or participated in fidelity monitoring before the end of one year from the completion of either the SNAP Facilitator Training or Annual SNAP Refresher Training, they will be required to attend SNAP Facilitator Training prior to returning in a facilitation/fidelity monitoring role.</p>	<p>Not Applicable</p>	<p>The Program does not provide SNAP Services.</p>
<p>NetMIS Training (For NetMIS Users prior to accessing NetMIS)</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person’s personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person’s Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>

December 17, 2025

<p>NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor’s level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>

December 17, 2025

<p>The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p>Not Applicable</p>	<p>The program has no eligible new hires.</p>
<p>Annual Training</p>		
<p>Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours)</p>	<p>Compliance</p>	<p>All Network-required trainings are documented in individual staff files and recorded on the FLN Training Log with all required details, including staff information, training hours, completion dates, and cumulative totals.</p>
<p>Child Abuse: Recognition, Reporting, and Prevention (Annually)</p>	<p>Compliance</p>	<p>Child Abuse: Recognition, Reporting, and Prevention training is completed annually and properly documented in staff training records.</p>
<p>Human Trafficking Intervention for Direct-Care Staff (Annually)</p>	<p>Compliance</p>	<p>Human Trafficking Intervention for Direct-Care Staff training is completed annually and supported by required documentation.</p>
<p>Information Security Awareness (Annually)</p>	<p>Compliance</p>	<p>Information Security Awareness training is completed annually and verified through certificates or attendance records.</p>
<p>Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)</p>	<p>Compliance</p>	<p>Prison Rape Elimination Act (PREA) Part 1 training is completed every two years and properly documented in training files.</p>
<p>Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)</p>	<p>Compliance</p>	<p>Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.</p>

December 17, 2025

Sexual Harassment (Every 2 Years)	Compliance	Sexual Harassment training is completed every two years and verified in staff files.
Trauma Responsive Practices (Every 2 Years)	Compliance	Trauma Responsive Practices training is completed every two years and documented on the FLN Training Log and in staff training files.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	Compliance	Florida Network Youth Suicide Prevention training is completed annually and documented in staff training files.
CPR (Every 2 Years - Check for current validity)	Compliance	CPR certification is current and renewed every two years in accordance with Network requirements.
First Aid (Every 2 Years - Check for current validity)	Compliance	First Aid certification is current and renewed every two years, with documentation maintained in the staff file.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	Not Applicable	The Program does not provide SNAP Services.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	Not Applicable	There were no incompleting trainings for any staff reviewed.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training hours received for the year.	Compliance	All direct-care Community Counseling staff meet the annual minimum requirement of 24 total training hours.
All direct care Shelter Staff meet the annual requirement of a minimum of 40 hours for residential programs licensed by DCF of the total hours of training received for the year. *This includes residential counselor or other direct care staff positions working with youth in shelter.*	Not Applicable	There are no shelter staff in this program; therefore, annual training hours are 24.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	Compliance	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
Additional Comments: There are no additional comments for this indicator.		

1.5 - Data Entry & Collection		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.5		Yes Policy # 1.5 Data Entry and Collection was approved by the Executive Director on 10/31/2025.
The program has a quality improvement process in place to review and improve accuracy of data entry and collection.	Compliance	The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.
Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement (as reported on most recent End-of-Month ('EOM') report).	Compliance	Client and service data are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement, as verified in the most recent End-of-Month (EOM) report.
Monthly review of statewide End-of-Month ('EOM') reports is evidenced. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.	Compliance	Monthly review of statewide End-of-Month (EOM) reports is completed and documented, including analysis of monthly data, fiscal year-to-date data, benchmarks, screening metrics, report card measures, and follow-up reporting indicators
Additional Comments: There are no additional comments for this indicator.		
1.6 - Risk Management/ Analyzing and Reporting Information		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.6		Yes Policy # 1.56 Analyzing and Reporting was approved by the Executive Director on 10/31/2025.
Data sources Reviewed		Dates Reviewed
Youth satisfaction survey summary 2024 and 2025; Log of incidents, accidents, and grievances; staff meeting minutes; annual program report to Board of Directors;		June - December 17, 2025

December 17, 2025

<p>The program provides reports of aggregated data and committee/workgroup minutes analyzing information.</p>	<p>Compliance</p>	<p>The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.</p>
<p>The program conducts quarterly case record reviews. (A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)</p>	<p>Exception</p>	<p>Provider documents case record reviews on a Case File Review checklist form and maintains a copy of the review in each youth file. The reviews are conducted after intake and at case closure. Missing items are noted on the form; however, there is no summary report that documents the findings of the case record reviews regarding compliance with the CINS/FINS requirements or identifying deficiencies to be addressed per the record reviews.</p>
<p>The program reviews incidents, accidents, and grievances at least quarterly.</p>	<p>Compliance</p>	<p>The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.</p>
<p>The program reviews customer satisfaction data at least annually.</p>	<p>Compliance</p>	<p>Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.</p>
<p>The program reviews outcome data at least annually.</p>	<p>Compliance</p>	<p>Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.</p>
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.</p>

December 17, 2025

<p>The program demonstrates program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the provider's Executive Committee on the Board of Directors.</p>	<p>Compliance</p>	<p>Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.</p>
<p>Evidence shows that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p>Compliance</p>	<p>Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.7 - Client Transportation</p>		<p>Not Applicable</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.7</p>		<p>Yes</p>
		<p>Policy #1.07 Client Transportation states NEED does not transport clients.</p>
<p>Supervisors complete a quarterly review of transport documentation and provide written feedback or coaching when deficiencies are found.</p>	<p>Not Applicable</p>	<p>Per the agency's policy, NEED does not transport clients.</p>
<p>The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>All drivers have an approved driver's license.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver's work performance and history, indicating no inappropriate behavior is likely to occur.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>The list of approved drivers are covered under the agency's automobile insurance.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>There is documentation of use of a vehicle that notes the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>Two staff accompany youth on each transport.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>

December 17, 2025

<p>If a 2nd staff member cannot be obtained for transport, the necessity of transport, the client’s history, evaluation, and recent behavior is considered and documented. Signed parental consent is obtained in advance of any single transport *Note: Parental consent can be obtained at admission and is a one-time event.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>If a single staff is transporting youth in a vehicle, there is evidence that the program supervisor approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>If a 2nd staff member cannot be obtained for transport, there is evidence that the transporting employee completed a check-in by phone at agreed-upon intervals with the senior program leader or designee, upon departure and arrival. The employee check-ins must be documented by the manager or designee receiving the call.</p>	<p>Not Applicable</p>	<p>NEED does not transport clients.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.8 - Client Contact Policy</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</p>		<p>Yes</p>
		<p>Policy # 1.08 Client Contact was approved by the Executive Director on 10/31/2025.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.9 - Community Referrals and Outreach Services</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</p>		<p>Yes</p>
		<p>Policy 1.09, Outreach Services was approved by the Executive Director on October 31, 2025.</p>

December 17, 2025

<p>Outreach activities include education about services offered and guidance on accessing those services.</p> <p>The following mandatory information of each outreach activity is entered into NETMIS: the title, date, duration (hours), zip code, location, description, estimated number of people reached, modality, target audience and topic.</p> <p>The activities include group presentations/discussions, individual meetings, short-term intervention groups, set up/display and distribution of materials at community events, conducting tours of facilities, and media events or interviews.</p>	<p>Compliance</p>	<p>The program’s outreach activities effectively educate the community about available services and provide clear guidance on how to access them. All required details, including title, date, duration, location, description, estimated attendance, modality, target audience, and topic, are accurately entered into NETMIS.</p>
<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.</p>
<p>The program has a lead staff member who conducts outreach, is designated to participate in local DJJ Board and council meetings and leads other outreach activities.</p>	<p>Compliance</p>	<p>A designated staff member serves as the program’s outreach lead, participates in local DJJ Board and council meetings, and coordinates all outreach efforts on behalf of the program.</p>
<p>This responsibility is specified in their job description.</p>	<p>Compliance</p>	<p>The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.</p>
<p>Full-Service agencies document meetings with local stakeholders (school districts, judges, and law enforcement) at least two times per year to discuss services available and needed improvements.</p>	<p>Not Applicable</p>	<p>Need is not a full-service agency.</p>
<p>Outreach activities include education about services offered and guidance on accessing those services. The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Outreach efforts include a variety of engagement methods such as group presentations, individual meetings, short-term intervention groups, informational displays at community events, facility tours, and media participation. These activities demonstrate strong community visibility and connection.</p>

December 17, 2025

<p>The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.</p>	<p>Compliance</p>	<p>The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.</p>
<p>Copies of agreements are forwarded to the Florida Network.</p>	<p>Compliance</p>	<p>Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>Domain Three</p>		
<p>3.2 - Admission Process</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.2</p>	<p>Yes</p> <p>Policy #3.02, Admission Process, was approved on 10/31/2025 by the Executive Director.</p>	
<p>A total of eight file(s) were reviewed during this evaluation period. Of these, four were open and four were closed. Among the open file(s), zero residential (RES) and four community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and four community counseling file(s) were reviewed.</p>		
<p><u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.</p>	<p>Exception</p>	<p>Six out of the eight total files reviewed, completed the screening within three days of receiving referral. The other two files showed that the screening was completed after the three days. However, one of those files had documentation that attempts were made to reach out the family but were unsuccessful until day five when family answered.</p>
<p>Youth and parents/guardians receive the following in writing</p>		
<p>Youth and parents/guardians are provided available service options in writing.</p>	<p>Compliance</p>	<p>Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.</p>
<p>Youth and parents/guardians are provided “Rights and Responsibilities of Youth” in writing.</p>	<p>Compliance</p>	<p>Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.</p>

December 17, 2025

<p>Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.</p>	<p>Compliance</p>	<p>Parents and guardians were provided the “Rights and Responsibilities of Parents” brochure at intake, and signed acknowledgment forms were present in all records.</p>
<p>The following is also available to the youth and parents/guardians:</p>		
<p>Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).</p>	<p>Compliance</p>	<p>Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.</p>
<p>Youth and parents/guardians are provided information regarding the programs grievance procedures.</p>	<p>Compliance</p>	<p>All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.</p>
<p>If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.</p>	<p>Not Applicable</p>	<p>None of the youth/families of the files reviewed declined services.</p>
<p>The intake took place in a setting that allows the client to feel safe and heard.</p>	<p>Exception</p>	<p>Seven out of the eight total files reviewed contained documentation indicating the place and date intake was completed. One of the files did not show any information of where that intake took place only the date. No progress notes were found to ascertain location.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</p>		<p>Limited</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.3</p>		<p>Yes Policy #3.03, Nirvana Assessment, was approved 10/31/25 by the Executive Director.</p>
<p>NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.</p>	<p>Compliance</p>	<p>All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.</p>

December 17, 2025

<p>NIRVANA Assessment was conducted by a bachelor’s or master’s degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI). (Review Staff Roster to verify Counseling/Case Management staff degree and completion of MI and NIRVANA training)</p>	<p>Compliance</p>	<p>All assessments were completed by qualified bachelor’s or master’s level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.</p>
<p>All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.</p>	<p>Exception</p>	<p>Out of the eight files reviewed, five of them showed that the NIRVANA was entered in NetMIS after the three days of completion. The remaining three showed they were entered on time.</p>
<p>The supervisor's signature is documented on the completed NIRVANA Assessment and/or the chronological note and/or the interview guide that is located in the youths’ file within 7 business days.</p>	<p>Exception</p>	<p>Two of the files reviewed contained the supervisor's signature after the seven days window.</p>
<p>A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.</p>	<p>Compliance</p>	<p>All applicable files contain a NIRVANA Post-Assessment that is completed at discharge for youth who have a length of stay that is greater than 30 days.</p>
<p>A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.</p>	<p>Exception</p>	<p>Only two out of the eight files reviewed needed a re-assessment. One was completed on time; however, one was due by 11/26/25 and was not completed until 11/30/25.</p>
<p>All files must have the interview guide and/or printed NIRVANA.</p>	<p>Compliance</p>	<p>Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.4 - Case Management, Counseling & Non-Residential Services Policy</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.4</p>		<p>Yes Policy # 3.07, Service Plan, was approved 10/31/25 by the Executive Director.</p>
<p>Each client is assigned a Counselor.</p>	<p>Compliance</p>	<p>Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.</p>

December 17, 2025

The following is also available to the youth and parents/guardians:		
Community Counseling Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or nonlicensed staff working under the direct supervision of a licensed staff.	Exception	One of the records reviewed did not include any documentation of individual or family counseling services provided.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	Exception	The one record lacking documentation of counseling services did not provide reasons why weekly sessions were not provided. Progress notes were limited to recording only follow ups that were conducted.
If case management needs extend beyond the counselor's role, a case manager is assigned.	Not Applicable	At the time of the review, NEED did not have separate case management staff. All counseling and case management services are provided by the assigned counselor.
Case Manager establishes appropriate referrals to services.	Not Applicable	None of the eight cases reviewed had a separate case manager assigned. Appropriate referrals were made by the assigned counselor.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed session/s.	Exception	One of the records did not include any documentation of services provided.
If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.	Not Applicable	None of the eight cases reviewed documented mental health or substance abuse services needed outside of the program's capacity.
For youth receiving Respite Services (DV, Probation & PDC): A minimum of one family counseling session is offered to address reunification planning and related concerns. If the session is not conducted, the reason is documented in the youth's case file, including any barriers to participation or service delivery.	Not Applicable	The provider did not receive any referrals for these respite services because they are not applicable for community counseling programs.
Clients that do not receive services for 30 days or more have their case closed.	Not Applicable	Documentation supported all records reviewed were provided services for the duration of time in the program.

December 17, 2025

<p>Direct supervision is documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019) or on a program developed form which contains the same information.</p>	<p style="text-align: center;">Exception</p>	<p>Direct supervision is documented on an MHSA 019 log on a weekly basis, with documentation of sessions that were cancelled due to holidays. Some of the supervision notes for three of the four counselors reviewed showed some of the sessions were not completed for a total of one hour, but were documented as one-half or three-fourth hour.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.5 - Adjudication Services: Case Staffing</p>	<p style="text-align: center;">Satisfactory</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</p>	<p>Yes</p> <p>Policy # 3.05 Adjudication Services: Case Staffing was approved was approved by the Executive Director on 10/31/2025. Per the policy, NEED has agreed to convene its case staffing with the Orange County Youth Shelter. Per the Executive Director, the program has not received any requests for case staffing during the annual review.</p>	
<p>A total of zero file(s) were reviewed during this evaluation period. Of these, zero were open and zero were closed. Among the open file(s), zero residential (RES) and zero community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and zero community counseling file(s) were reviewed.</p>		
<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum):</p> <ol style="list-style-type: none"> 1. the youth/family is not in agreement with services or treatment; 2. the youth/family will not participate in the services selected, 3. the youth's referring problem has not shown substantial improvement within six weeks of initiating counseling. 4. the program receives a written request from the parent/guardian or any other member of the committee 	<p>Not Applicable</p>	<p>Per the Executive Director, the program has not received any requests for case staffing during the annual review.</p>
<p>Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>

December 17, 2025

Notification to the family is sent no less than 5 working days prior to staffing.	Not Applicable	No eligible items to review.
Notification to the committee is sent no less than 5 working days prior to the staffing date.	Not Applicable	No eligible items to review.
A written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	Not Applicable	No eligible items to review.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	Not Applicable	No eligible items to review.
At a minimum, the case staffing is attended by:		
Local school district representative	Not Applicable	No eligible items to review.
DJJ rep. or CINS/FINS provider	Not Applicable	No eligible items to review.
Other members may include:		
State Attorney's Office	Not Applicable	No eligible items to review.
Mental health representative	Not Applicable	No eligible items to review.
Substance abuse representative	Not Applicable	No eligible items to review.
Law enforcement representative	Not Applicable	No eligible items to review.
DCF representative	Not Applicable	No eligible items to review.
Others requested by youth/family	Not Applicable	No eligible items to review.
The program has an established case staffing committee, and has regular communication with committee members.	Compliance	The program maintains an established case staffing committee with active and consistent communication among all members.
The program has an internal procedure for the case staffing process, including a schedule for committee meetings.	Compliance	Regular collaboration and communication with case staffing committee members are maintained to ensure coordinated planning and support for youth and families.
Additional Comments: There are no additional comments for this indicator.		

December 17, 2025

3.6 - Adjudication Services: CINS Petition Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.6		Yes Policy # 3.06 Adjudication Services: CINS Petition Process was approved by the Executive Director on 10/31/2025. Per the policy, NEED has agreed to convene its case staffing with the Orange County Youth Shelter. Per the Executive Director, the program has not filed any CINS petitions during the annual review.
If applicable, the program works with the circuit court for judicial intervention for the youth/family, as applicable, including required attendance at all court hearings without subpoena.	Not Applicable	Per the Executive Director, the program has not filed any CINS petitions during the annual review.
The Case Manager/Counselor completes a review summary prior to the court hearing.	Not Applicable	NEED has not processed any CINS petitions during the review period.
Additional Comments: There are no additional comments for this indicator.		
3.7 - Service Plan		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.7		Yes Policy # 3.07, Service Plan, was approved 10/31/25 by the Executive Director.
A Case/Service Plan is developed within seven (7) working days of the youth's intake in the shelter program.	Not Applicable	This is a community counseling provider.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA in the community counseling program.	Compliance	The Case/Service Plan is completed within one contact of the NIRVANA, demonstrating prompt follow-up and coordination.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	Compliance	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.

December 17, 2025

Youth and parents/guardians receive the following in writing		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	Compliance	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	Exception	One of the records did not include any documentation of services to be provided and/or location.
The plan identifies the person(s) responsible for implementing each service or action step.	Compliance	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan.	Compliance	The program uses the Florida Network NetMIS service plan form. The printed forms maintained in the files do not include required target date or completion date and that information was not documented on the service plans for four of the eight service plans reviewed. However, upon reviewing the youth records in NetMIS, it was noted that target dates were entered for all four youth.
The actual completion date(s) are documented in the service plan.	Exception	Actual completion date is not documented on one of four applicable service plans.
The signature of the youth is documented in the service plan.	Compliance	Youth signatures are present on plans, confirming their participation and agreement with the identified goals and services.
The signature of the parent/guardian is documented in the service plan.	Compliance	Parent/guardian signatures are obtained, reflecting engagement and shared responsibility in the service planning process.
If unavailable, the absence is documented with a reason on the plan.	Not Applicable	Signatures of parent/guardian were obtained for all of the service plans reviewed.
The signature of the counselor is documented in the service plan.	Compliance	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.

December 17, 2025

The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	Exception	None of the eight cases reviewed showed where the licensed professional reviewed the service plan within seven days of plan completion. The clinical summary completed documented the reviews around a 30 day timeframe.
The date of plan initiation is clearly indicated.	Compliance	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.
The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):		
At, 30 Days, following plan initiation.	Exception	Thirty day service plan reviews were not completed timely in three of the eight records reviewed.
At, 60 Days, following plan initiation.	Exception	Sixty day service plan reviews were not completed timely in five of the eight records reviewed.
At, 90 Days, following plan initiation.	Exception	Ninety day service plan reviews were not completed timely in three applicable records reviewed.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	Not Applicable	None of the records reviewed had service dates exceeding six months.
Additional Comments: There are no additional comments for this indicator.		
3.8 - Youth Records		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.8		Yes
		Policy 3.08, Youth Records & Storage, was approved by the Executive Director on October 31, 2025.
All records are marked "confidential".	Compliance	All youth records were clearly marked "Confidential," ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential" and only accessible by staff.	Compliance	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked "confidential".	Compliance	When transported, all records were placed in locked, opaque containers marked "Confidential," maintaining privacy and data security.

December 17, 2025

<p>All records are maintained in a neat and orderly manner.</p>	<p>Compliance</p>	<p>Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.</p>
<p>COMMUNITY COUNSELING FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Community Counseling Intake Form 5. Suicide Assessment (if needed) 6. NIRVANA full Assessment 7. Plan of Service 8. Chronological case notes 9. Copies of referrals made (if needed) 10. Discharge summary once the case is closed 	<p>Compliance</p>	<p>Each Community Counseling file included all required documents, including a table of contents, screening forms, informed consent, intake documentation, NIRVANA assessment, Plan of Service, chronological notes, referrals, and discharge summary.</p>
<p>If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Not Applicable</p>	<p>The program does not keep electronic records.</p>
<p>Records are retained for five years after the termination date of the contract that is funding the youth's service.</p>	<p>Compliance</p>	<p>Records were retained in compliance with policy for a minimum of five years following the termination date of the contract funding the youth's services.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

December 17, 2025

3.10 - Discharge and Follow Up		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.10		Yes
		Policy # 3.10, Case Termination/Discharge, was approved 10/31/25 by the Executive Director.
30 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were completed within 30 days post-discharge, with documentation confirming continued client stability and connection to recommended services.
60 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
Each file contains a discharge summary that describes the reason for termination.	Compliance	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, and progress of the youth and family.	Exception	One record was missing the progress notes and did not include information on progress of the youth.
Each file contains a discharge summary that describes the living arrangements of the child at termination. If the child is not returned to the family at termination, the discharge summary must contain the reasons for the alternative placement, plans for the child's living arrangement, and interim objectives set that will accomplish an eventual return, if possible and when appropriate.	Compliance	All discharge summaries documented the youth's living arrangements at termination. For youth not returning home, the file included the reasons for alternative placement, plans for ongoing stability, and goals supporting future reunification when appropriate.
Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.	Compliance	Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.

December 17, 2025

<p>Each file contains a NIRVANA Post Assessment.</p>	<p>Compliance</p>	<p>Each file contained a completed NIRVANA Post-Assessment, documenting the youth’s progress and outcomes at discharge.</p>
<p>For cases that are referred for services by Truancy Court for FINS services, or to the case staffing committee for consideration of a CINS petition as a result of truancy related issues; youth having been deemed Truant by the Court, the Provider shall verify school attendance during 30- and 60-day follow-ups if the youth remains subject to compulsory education. If verification cannot be obtained, efforts are documented in the youth’s file.</p>	<p>Not Applicable</p>	<p>None of the records reviewed indicated referral source was truancy court.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>Domain Six</p>		
<p>6.2 - Suicide Prevention</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 6.2</p>		<p>Yes Policy 6.2, Suicide Prevention in Community Counseling Programs, was approved by the Executive Director on October 31, 2025.</p>
<p>Shelter maintains a written suicide prevention & response plan approved by the Florida Network.</p>		<p>N/A</p>
<p>SNAP maintains a written suicide prevention & response plan approved by the Florida Network.</p>		<p>N/A</p>
<p>Community Counseling maintains a written suicide prevention & response plan approved by the Florida Network.</p>		<p>Yes</p>
<p>Core Requirements All Programs: Upon intake, every youth is screened for suicidality using the five Florida Network questions.</p>	<p>Compliance</p>	<p>All youth are consistently screened for suicidality during intake using the five Florida Network questions.</p>
<p>Core Requirements All Programs: Screening results are reviewed, signed by a supervisor, and filed in the youth’s case record.</p>	<p>Compliance</p>	<p>Screening results are promptly reviewed, signed by a supervisor, and accurately filed in each youth’s case record.</p>
<p>A “yes” to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.</p>	<p>Compliance</p>	<p>Any positive response immediately triggers a full suicide risk assessment by a qualified LMHP or a clinician under direct LMHP supervision.</p>

December 17, 2025

Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Core Requirements (All Programs) All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Core Requirements (All Programs) If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Core Requirements (All Programs) Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Core Requirements (All Programs) If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
When an immediate assessment is not possible, families receive community resource information.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	Not Applicable	The program did not have any youth screened as a suicide risk during the review period.
Additional Comments: There are no additional comments for this indicator.		